

Maine

Office of Substance Abuse

Technical Review Report:
Phase I—Assessment of State Management and
Oversight of Opioid Treatment

September 26, 2003

Prepared for
Division of State and Community Assistance
Center for Substance Abuse Treatment

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I. Introduction

A. PURPOSE OF THE TECHNICAL REVIEW

The State Systems Development Program (SSDP) was initiated by the Center for Substance Abuse Treatment (CSAT) of SAMHSA to enhance the viability and effectiveness of national and State-level substance abuse service delivery systems. The Technical Reviews project is one of SSDP's major components—an assessment of statewide systems that examines system strengths, identifies major operational issues, and measures progress toward meeting Substance Abuse Prevention and Treatment (SAPT) Block Grant objectives. The project focuses on providing SAMHSA, CSAT, and the States with a framework for effective technical assistance (TA), technology transfer, and new policy initiatives.

Two types of reviews are conducted through the Technical Reviews project: State-Requested Reviews, in which States identify their most pressing concerns and select one or more issues for indepth review, and Revised Core Elements Reviews, in which CSAT has identified certain issues for review.

The Maine Office of Substance Abuse (OSA) requested a Technical Review to examine statewide opioid treatment oversight and programming. This State-Requested Technical Review had the following objectives:

- To review the role of the State Methadone Authority (SMA), particularly its regulatory role and exercise of its oversight responsibility.
- To assess the treatment being provided in the opioid treatment programs (OTPs), including an appraisal of the extent to which the programs are employing best practices.

B. METHODOLOGY

The Technical Review is conducted by an independent contractor on behalf of CSAT. The intended audience is CSAT and the Single State Authority (SSA) responsible for delivering services supported by SAPT Block Grant funds.

The first step in the Technical Review process is the formation of the Technical Review team composed of specialists with expertise related to the issues under review. Prior to the onsite review, the reviewers examine documents provided by the SSA, other relevant agencies, and programs. Additional documents describing agency and program operations are obtained on site and reviewed either at that time or following the site visits.

Following the site visits, the reviewers conduct an exit conference with officials to discuss preliminary findings and TA recommendations. Following the site review, the reviewers complete the analysis of all documentation and generate draft reports that integrate the findings with the results of the site visits. The draft reports are submitted to CSAT and the SSA for review and comment. Final reports are then produced that incorporate the corrections and revisions agreed to by OSA, CSAT, and the reviewers.

The State-Requested Review for Maine was conducted in two phases:

Phase I—Systems Review of State Authority

This phase of the State-Requested Technical Review explores how the State is currently providing oversight and exercising regulatory authority for opioid treatment, and considers options for making this system more effective. Areas reviewed included:

- Role of the SSA and SMA
- Monitoring and regulatory processes, including client outcome data and reports from providers
- Position of opioid treatment in the overall continuum of care for substance abuse treatment
- Role of licensing/certification
- Impact of national accreditation
- Relationships with other agencies and organizations such as the Portland Police, the State Attorney General, and the State associations for pharmacists and for emergency medicine.

Data for this phase of the review were collected through interviews with key individuals, as well as review of available documents.

Phase II—Review of Clinical Practices in Methadone Clinics

Phase II of the State-Requested Technical Review will analyze the provider system for opioid treatment in the State. Information will be gathered from provider agencies on how opioid treatment services are being provided, the extent to which providers are employing best practices in their treatment, and how services might be enhanced. Areas that may be reviewed include:

- Program capacity and current utilization
- Client characteristics

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- Admissions process including requirements, assessment, and screening
 - Availability, access to, and utilization of auxiliary services including case management
 - Treatment issues, including treatment plans and progress notes, dosage levels, treatment of polysubstance abuse, and responses to positive urine tests
 - Options for abstinence and drug-free treatment
 - Staffing patterns
 - Client outcomes, including employment, criminal justice, and housing
 - Client satisfaction, including interviews with clients where feasible
 - Quality assurance systems, including diversion management
 - Data management capacity and reporting requirements

An interview protocol was developed to guide provider interviews. OTPs were visited to gather data for this phase of the review. In addition, selected substance abuse treatment programs were visited to gather additional perspectives on the interface between opioid treatment and other substance abuse treatment services.

Two reports will be prepared as a result of this two-phase review:

- Assessment of State Management and Oversight of Opioid Treatment
- Assessment of the Opioid Treatment Provider System

This report, Assessment of State Management and Oversight of Opioid Treatment, summarizes the findings of the first phase of the review.

C. GENERAL LIMITATIONS

The information presented in the Technical Review reports is based on analysis of the interviews conducted at OSA, treatment providers, and other Maine agencies and review of available documents. The scope and depth of the review are limited by the amount and quality of the documentation and the amount of time spent on site.

The findings in this Technical Review report do not constitute audit findings and should not be used for that purpose. The fiscal information included is based on data provided by the agencies reviewed.

The findings represent organizational development and compliance issues identified in the SAPT Block Grant (Catalogue of Federal Domestic Assistance Number 93.959), and they are intended to serve as the basis for TA developmental action plans to improve Maine's capacity to deliver the services required under the SAPT Block Grant. This report is intended solely for the use of CSAT, Maine, and their appropriate designees.

D. STATE REVIEW PARTICIPANTS

A list of the Maine Technical Review participants is presented in exhibit I-1. Appendix A provides a list of all Maine personnel interviewed during the Technical Review. Appendix B provides a list of acronyms relevant to Maine.

Exhibit I-1. Maine Review Participants

AGENCY NAME:	Office of Substance Abuse
LOCATION:	Augusta, Maine
DIRECTOR:	Kimberly Johnson
REVIEW PERIOD:	June 23–27, 2003
REVIEWERS:	Sigrid Hutcheson, Ph.D., Team Leader Lawrence Hobdy, M.S., Clinical Specialist Sharon Morello, RN, BSN, Clinical and Management Specialist

II. Context for the Review

This State-Requested Review of opioid treatment in Maine occurred in the context of significant changes in the management and oversight of opioid treatment at both the Federal and State levels.

A. NATIONAL OVERSIGHT

On the national level, the Federal approach to regulatory oversight for opioid treatment has made a dramatic shift in the past few years. After thirty years of Food and Drug Administration (FDA) inspections providing most of the Federal oversight, the Federal regulatory program for opioid treatment has changed to an accreditation-based approach directed by SAMHSA. The previous FDA inspection program involved process-focused regulations, some of which were somewhat prescriptive and not entirely supportive of newer best practice guidelines. The new accreditation-based regulatory approach is intended to encourage individualized care, best practices, greater accountability, an outcomes focus, and greater flexibility for treatment professionals. The intent of the new approach is to make programs more clinically driven rather than administratively driven. The new Federal regulatory approach also gives States greater regulatory flexibility. With the new regulatory approach, States can choose to establish detailed practice oversight and involvement, defer active involvement in regulatory oversight to the national accrediting bodies, or to develop an approach blending some features of each approach.

New Federal regulations (42 CFR Part 8) require that all OTPs must be certified by SAMHSA. To be certified, an OTP must be accredited by a SAMHSA-approved accreditation body. The three national accrediting associations approved by SAMHSA for accrediting OTPs are CARF...The Rehabilitation Accreditation Organization (CARF), Council on Accreditation for Child and Family Services (COA), and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).

B. STATE LEVEL CONTEXT

At the State level, Maine does not have a long history of opioid treatment and, until the past few years, appeared not to have experienced the dramatic increase in heroin use being experienced by the rest of the New England region. Opioid treatment began in Maine in 1995 with the opening of Habit Management in South Portland, closely followed by the establishment of Discovery House. Habit Management closed in 1996 and its clients transitioned to Discovery House. A second Discovery House program was established in Winslow in 1998.

In 1999, in the annual report to the Legislature on the status of opioid treatment in Maine, OSA and its Opiate Addictions Treatment Alternatives Group reported that admissions to Discovery House in Portland had dropped by 17 percent and that a total of 50 clients were enrolled in the new Discovery House program in Winslow. The available data on the need for opioid treatment led OSA to conclude:

“There is no expectation that methadone services will be expanded beyond the South Portland and Winslow facilities. It is doubtful that the number of heroin users will be great enough to support a third location.” The 1999 report recommended that this be the final report of this workgroup since the group had helped establish two opioid treatment facilities, which appeared to have met the treatment needs of the State’s population. Since the movement toward requiring national accreditation of opioid programs had already been announced, OSA expected to use the requirement of national accreditation as a key part of its continued oversight of these programs.

In 1999, Discovery House in Winslow failed to meet some State licensing standards and was threatened with closure. Rather than attempt to close the program which would have left clients with no access to treatment, OSA and the licensing unit provided intensive TA. The outstanding issues were remedied to enable the agency to receive full licensure.

In 2000-2001, OSA supported the establishment of a new OTP in Bangor at Acadia Hospital to provide better geographic distribution of services. To counteract the opposition of the community to the establishment of this program, a year-long impact evaluation was conducted to track the impact of the program on the community.

In 2001, a final new program was opened in Westbrook by CAP Quality Care located relatively close to Discovery House in South Portland, creating some competition and movement of staff and patients between these two programs. However, both programs continue to attract new clients.

C. EMERGENCE OF THE PROBLEM

In March and April of 2002, the news media began reporting “methadone deaths” in the greater Portland area. In an attempt to determine more precisely the actual cause of these deaths, an analysis of Medical Examiner reports of the drug deaths for the period 1997-2002, both suicidal and accidental, was conducted. The Maine Drug-Related Mortality Patterns: 1997-2002 (Marcella H. Sorg, RN, Ph.D., D-ABFA, and Margaret Greenwald, M.D. December 27, 2002) report shows that the number of deaths rose from 34 in 1997 to 90 in 2001, with a total of 161 projected for 2002. The increase in deaths appeared to be primarily related to the use of prescription drugs, especially those prescribed for pain, anxiety, and depression. The majority of the deaths involved narcotics, including methadone, Oxycontin, fentanyl, and others. The increase in drug deaths appears to be due primarily to accidental not suicidal overdoses. It is not clear to what extent the deaths were actually caused by methadone, as opposed to being caused by some other condition or combination of drugs in individuals who were taking methadone.

The deaths received widespread coverage in the local and national press, and created the image of methadone as causing deaths. The press reported that substantial amounts of methadone were being diverted from treatment programs and sold to drug users. In some cases, bottles from methadone

clinics were reported to have been found at the scene of overdoses. It is important to note that this pattern of overdose deaths is not confined to Maine. For example, a recent study in the *Journal of the American Medical Association* reported that methadone-related unintentional deaths in North Carolina increased 500 percent between 1997 and 2001. However, of the 198 North Carolina residents who died from methadone overdoses during that period, only 4 percent were reported to be enrolled in opiate treatment programs. This study also reported that the amount of methadone purchased by pharmacies and hospitals increased 400 percent during the same time period, suggesting the increased use of methadone for pain management. The researchers who conducted this study suggest that it is unlikely that the people who overdosed on methadone had received the treatment for heroin addiction. (Ballesteros, M.; Budnitz, D.; Sanford, C.; Gilchrist, J.; Agyekum, G.; and Butts, J. Increase in Deaths Due to Methadone in North Carolina. *Journal of the American Medical Association*, 290 (1): 40. 2003) (Abstract <http://www.jointogether.org/y/0,2521,564632,00.html> [accessed July 21,2003])

A number of factors appear to have converged to set the stage for the drug related deaths including the following:

- The New England heroin epidemic spread to Maine, leading to an increase in heroin users. Many of these users are relatively new addicts who were not knowledgeable about the drugs they were using.
- Oxycontin was increasingly being prescribed by physicians for pain without sufficient attention to the potential for abuse.
- Methadone was being prescribed for pain by physicians, including some who were attempting to avoid the negative consequences of Oxycontin.
- The medical community had limited experience and training in treating clients with opioid addiction.
- The opioid treatment provider system was very new with few staff having extensive experience in working with methadone clients.
- Options for opioid treatment were limited, leaving some clients with addiction to opioids with no viable treatment options.

When the deaths began to be reported in the media, the public was not well-informed about opioid addiction and treatment; therefore, much of the initial reaction was not based on either accurate data about the deaths or on good information on appropriate opioid treatment. Even though sufficient information was not available to fully analyze the situation, there was no disagreement that action had to

be taken to reduce the number of deaths that appeared to be drug-related. The following chapter describes the interventions developed by OSA and a wide array of partners to improve the available information and take concrete action to reduce occurrence of conditions that appeared to be contributing to the deaths. While this has been an extremely challenging year for all the individuals involved, a review of all the actions taken suggests that the approach Maine took to addressing the problem could serve as a model for other States faced with similar situations.

III. Key Interventions by OSA and Its Partners to Improve Opioid Treatment System in Maine

When the problem of overdose deaths became public, OSA mobilized a multi-faceted effort to gain a better understanding of the problem and to address systemic issues that appeared to be contributing to the problem. This chapter describes briefly the major initiatives begun throughout Maine in response to concern about drug overdose deaths. The public nature of the problem and the openness and collaborative approach taken by OSA appear to have promoted widespread participation of partners to gather knowledge and to develop a variety of strategies. This has been a very stressful period, with intense media scrutiny, widespread public criticism, and distress over the number of lives that were lost. However, OSA has led a campaign that appears to be a model strategy for responding to a public crisis and mobilizing partners in crafting a plan for response. The issue of the deaths has moved from being a substance abuse problem to being seen as a public health problem that requires interventions at many points in order to develop an effective response. One notable feature of the Maine response to the problem of overdose deaths was that individuals and groups that typically do not work as partners, including public health staff, substance abuse treatment providers, State and local police, the Maine Drug Enforcement Agency (DEA), medical professionals, legislators, the Attorney General's office, and opiate users came together to collaborate and address the crisis. While these partners brought different opinions and attitudes about opioid use and treatment, they all contributed their strengths and assets to the common effort.

A. EDUCATION PLAN

OSA recognized early on that opioid treatment was not well understood by any of the sectors involved with it. OSA, with the support of CSAT TA, initiated a three-part public education program to provide up-to-date information appropriate to each of the target audiences.

People in Treatment and Active Drug Users

The purpose of this component of the education program was to educate those who are receiving opioid treatment about their responsibility for the methadone they receive, as well as of the consequences of sharing it with others. Specifically, clients were made aware that sharing methadone could result in them being terminated from treatment, losing their take-home privileges, losing their opportunity to remain in recovery, and ultimately, causing the treatment programs to be closed. Educational materials produced included posters that were distributed to OTPs ("Share the message not the methadone. It's my methadone, my recovery, my responsibility."). This phase of the education program also attempted to inform drug users about the dangers of taking methadone that was not prescribed for them, particularly the risks of death from overdose. Materials for this audience included 10-minute phone cards ("Take 10 minutes on us to think about it.") and paper napkins carrying

messages (“Methadone is serious medicine. Don’t mix, share, borrow”). These educational materials were distributed to sites where the target audience tends to congregate such as OTPs, homeless shelters, and needle exchange sites.

Education for the Medical Community and Substance Abuse Treatment Providers

Both the medical community and the substance abuse treatment community had little exposure to OTPs. An extensive program of education for medical and substance abuse treatment professionals began in October 2002 with a Grand Rounds—Methadone Treatment of Opiate Dependence and Related Issues, a presentation by the Director of CSAT, Westley Clark, M.D., J.D., M.P.H., followed by a panel discussion. Two additional panel presentations were conducted, one in November 2002 on Opiate Agonist Therapy: Best Practices and Clinical Challenges and one in February 2003 on Continuing the Dialogue on Methadone Treatment in Southern Maine.

The education series was well attended by a variety of health care professionals and received positive reviews. OSA has now built on these initial presentations by scheduling ongoing panels on a monthly basis entitled, “Continuing the Dialogue—How do we Communicate?,” with the goal of continuing to provide the healthcare community with current information, as well as the opportunity to come together to discuss emerging issues of concern about opioid treatment.

The goal of these regularly scheduled sessions is to provide information and to build better communication within the medical and substance abuse treatment communities. Evaluations of the sessions indicate that the treatment community is becoming somewhat open to the value of opioid treatment. However, substance abuse treatment providers are reported to have low regard for OTPs in general and, in particular, to be alienated by the for-profit nature of three of the four OTPs.

Education of General Public

OSA also began efforts to educate the general public that methadone is medicine, not a street drug. Two public service radio announcements have been produced by individuals in recovery who are using methadone to take control of their lives. These radio spots were being aired for the first time during the State-Requested Technical Review (June 2003).

B. STUDIES AND DATA COLLECTION

One of the keys to developing new policies in response to the emerging drug problem is to have valid and reliable data to serve as the basis for policy development. Initial efforts to develop new policies were hampered by lack of accurate data. However, a set of studies has been completed, each of which contributed to a better knowledge base.

Maine Drug-Related Mortality Patterns: 1997–2002

(Marcella H. Sorg, RN, Ph.D., D-ABFA, and Margaret Greenwald, M.D. December 27, 2002)

The Maine Drug-Related Mortality Patterns: 1997–2002 study was funded by the Maine Justice Assistance Council with funds awarded by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice. This study involved a retrospective review of the 374 medical examiner cases between 1997–2002 in which a drug or toxic substance was involved in a death. The purpose of this study was to investigate the details of which drugs were involved in the deaths, which drugs appeared to be the main cause of death, and the characteristics of the individuals who died. The study concludes that “The dramatic rise in overdose deaths in Maine is due mainly to a rise in accidental overdoses, primarily involving illicit and prescription narcotics in combination with other prescription drugs and alcohol. The most common drugs seen are narcotic pain medications (including methadone) and heroin. Medications prescribed for pain, depression, and anxiety all appear frequently as causes of death, often co-occurring.” The study profiles the affected population as being at greater risk of death because of “...a history of substance abuse, underlying natural disease, and use or misuse of multiple prescription medications.”

Oxycontin Abuse: Maine’s Newest Epidemic

(Substance Abuse Services Commission in conjunction with the Maine Office of Substance Abuse. January 2002)

The Oxycontin Abuse: Maine’s Newest Epidemic study was prompted by the awareness that Maine was one of the first States to identify problems caused by Oxycontin and other prescription narcotics. The Maine DEA reported that crime related to prescription narcotic abuse had increased dramatically, and OSA reported that substance abuse treatment admissions for narcotic abuse were increasing sharply. This report gathered information from individuals who were recovering from opiate addiction and a number of existing databases, as well as from experts in areas including medicine, law enforcement, and treatment. The study recommends (1) increased access to treatment, especially treatment for opiate addiction; (2) increased public education; (3) expanded participation in the Maine Youth Drug and Alcohol Use Survey, which will begin tracking prescription drug use to gather data to guide prevention; (4) increased funding for law enforcement to control diversion of legal drugs to illegal use; and (5) development of a statewide electronic prescription monitoring program for Schedule II narcotics.

A Public Health Strategic Plan to Address Opiate Abuse and Overdose: A Report from the MCPH/MPHA/OSA Opiate Abuse and Overdose Project

(Ann C. Conway, Ph.D. December 31, 2002)

The Maine Center for Public Health and the Maine Public Health Association joined in this study based on the premise that opiate abuse and overdose have become a significant public health problem in

Maine. Some of the evidence cited by the groups include the dramatic increase in overdose fatalities, increased admissions to treatment, rising crime rates and drug prosecutions associated with opiates, and rising hepatitis C rates among opioid users. This project included a literature review emphasizing best practices, a multi-stakeholder Task Force, key informant interviews, and the formulation of policy options. The policy recommendations include the following categories:

- Community awareness and education
- Overdose prevention strategies
- Provider education and provider-related policies
- Emergency response
- Methadone-specific strategies
- Monitoring and investigation
- Treatment
- Law enforcement
- Research

This task force report presents the most comprehensive assessment of the nature of the public health problem, along with a comprehensive array of strategies to address the problem.

Illicit Opiate Use in Maine

(Robert Heimer, Ph.D., et al. Yale University Study Conducted in Summer 2002)

This study was sponsored by Purdu Pharma to gain understanding of the characteristics of individuals who are using Oxycontin illicitly. Of particular interest was the drug history, demographics, socioeconomic status, and medical conditions of individuals who are using Oxycontin illicitly. The investigators recruited 238 opiate users in Cumberland County but were able to recruit less than 30 subjects in Washington County. Preliminary findings for the Cumberland County sample of 238 individuals who were using opiates indicated that opiate use in the previous 30 days included 187 who used Oxycontin, 105 who used heroin, 165 who used other short-acting opiates and 59 who used methadone. In addition, these 238 individuals also reported that 222 had used other drugs illicitly and 134 had used alcohol to intoxication. In this study, 136 subjects reporting ever using methadone illicitly, and 59 reporting using it illicitly in the past 30 days. Respondents reported that of the estimated 10,323 illicit opiate doses taken, 506 (4.9 percent) were illicit methadone doses. Half of the illegal methadone was reported to be from pain prescriptions and half from treatment clinics. A full report of the study is not yet available. The information cited here was taken from printed materials distributed at a presentation about the study.

Evaluation of the Acadia Narcotic Treatment Program

(Jane Maxwell, Ph.D., Gulf Coast Addiction Technology Transfer Center, University of Texas at Austin, September 23, 2002)

Because of substantial community concern about opening a methadone program in Bangor, CSAT and OSA contracted for an evaluation of the impact and effectiveness of the Acadia Narcotic Treatment Program on the clients and on the community. Impact on clients is measured by comparing characteristics and problems of clients at admission and at one year followup. Impact on the community is measured by comparing crime statistics in Bangor before, and one year after, the program's opening. Analysis of ASI data collected at admission and on followup indicated that most of the clients showed statistically significant decreases in drug and alcohol problem index scores. Use of other drugs and alcohol was reported to have decreased, along with a decrease in psychological, employment, legal, and medical problems. The Bangor City Police Department reported a decrease in criminal activities typically associated with drug activity, such as theft and burglary. The report concludes that, on the criteria studied, the treatment program appears to be a success both in terms of impact on clients treated and on the community. This study is particularly significant since it provides some initial evidence of positive benefits for a community when opioid treatment is made available.

Maine Community Epidemiology Surveillance Network (CESN)

(Jointly sponsored by Maine Bureau of Health and Office of Substance Abuse)

Preliminary organizational efforts are being initiated by a multi-agency workgroup to establish a drug surveillance system network. An organizational meeting was held on June 10, 2003. This network is intended to study the spread, growth, and development of drug abuse in a community. Member organizations will each contribute information they routinely collect. Sources may include data from drug abuse treatment services, public health reports, law enforcement agencies, hospital emergency departments, the medical examiners office, help lines, and surveys. The objectives of this CESN are:

- To identify drug abuse patterns in defined geographical areas
- To establish drug abuse trends
- To detect emerging substances
- To provide information for policy development and program planning

The CESN will be extremely valuable in helping the State track emerging trends, determine high priority activities, allocate resources strategically, and develop appropriate public policy. Opioid addiction patterns appear to continue to change rapidly, and this surveillance system will give the State the ability to track trends and anticipate problems before they reach the crisis stage.

C. OVERSIGHT AND SURVEILLANCE

Licensing/Certifying Programs

Responsibility for licensing all substance abuse treatment programs was moved from the Department of Human Services to the Department of Behavioral and Developmental Services (BDS) in January 2001.

This move led to a reorientation of the licensing unit. The BDS licensing unit conducts licensing as an ongoing activity in which the licensing staff consults with programs, identifies problems and solutions, facilitates communication, and delivers TA. The licensing unit has systematically developed expertise in opioid treatment which enables licensing staff to be very effective in reviewing and regulating the treatment programs. The licensing unit's approach of monitoring, along with providing assistance and guidance to programs to help them comply with regulations, is very compatible with the CSAT approach, which suggests that regulation should be oriented toward clinically driven quality improvement. The licensing department evaluates each program once a year, and works closely with the OSA treatment unit.

In the past two years, all four OTPs have received two-year licenses.

- In January 2002, Acadia Narcotic Treatment Program received a 2-year license, replacing its initial 1-year license.
- In August 2002, CAP Quality Care received a 2-year license, replacing its initial 1-year license.
- In December 2002, Discovery House Winslow received a 2-year license replacing a 1-year license.
- In March 2003, Discovery House South Portland received a 2-year license replacing a 2-year license granted with a plan of compliance requiring a revisit.

The current substance abuse licensing regulations, dated September 3, 1996, are being updated and the updates are primarily modeled on the new CSAT guidelines. As an interim measure when overdose deaths were occurring and being investigated, SMA issued a memorandum in June 2002, directing programs to be open 7 days-a-week (removing the option for clients to have Sunday take-home doses), restricting take-home privileges by requiring clients to be in treatment for at least 3 months before any take-home privileges are allowed, and requiring State exception approval for any 14- or 30-day take-home privileges.

Accreditation

All four methadone treatment programs have received national accreditation in 2003.

- Discovery Winslow and Portland received a 3-year accreditation from CARF in February 2003.
- Acadia and CAP Quality Care received accreditation from JCAHO in May 2003.

The accreditation process established the fact that the programs have met the standards of their respective accreditation associations at the time of the accreditation visit. Demonstrating the achievement of the standards is an important milestone for the programs, but since accreditation visits only occur every three years, the accreditation process is of limited value for ongoing monitoring of the quality of the programs.

Pharmacy Board

The Pharmacy Board provides oversight and monitoring, as well as TA and guidance on how to establish adequate safeguards to maintain security of controlled substances. For the OTPs, the Pharmacy Board provides oversight of storing and dispensing methadone. The Pharmacy Board also monitors staffing to ensure that the OTPs are adequately staffed with pharmacists. The Pharmacy Board conducts periodic inspections and investigates situations when warranted. The Pharmacy Board is oriented to providing consultation and assistance to pharmacies in establishing good procedures and policies to manage pharmaceuticals.

D. LEGISLATION

After the third attempt, legislation was passed in May 2003 to establish an electronic system for monitoring Schedule II, III, and IV controlled substance prescriptions. OSA will be responsible for implementing the electronic monitoring system which is estimated to take a year to establish. This electronic monitoring system is intended to improve client care by identifying problems with prescribing or with individual clients. When the electronic monitoring system is fully operational, OSA will have better data on how controlled substances are being prescribed and dispensed. Physicians will be able to access information on individual clients when physicians are concerned about prescribing. The electronic monitoring system is not intended for law enforcement. The hope is that this electronic monitoring system will deter physicians from over prescribing and stop patients from prescription shopping.

With strong support from the Attorney General's office, legislation was passed in the past several years to strengthen drug enforcement by preventing interstate and international smuggling of illegal drugs in the State by creating the crime of illegal importation of scheduled drugs. An act was also passed to place greater controls on prescription drugs by controlling the illegal diversion of prescription narcotic drugs and abuses of designer club drugs with penalties for trafficking, along with controls on prescription blanks and acquiring drugs by deception.

E. INTERAGENCY WORKGROUPS AND INITIATIVES

One promising and effective strategy developed during the past several years is interagency workgroups and collaboratives.

Opioid Treatment Workgroup

Since September 28, 2000, the four opioid treatment providers have been meeting with SMA and OSA representatives, BDS licensing staff, and other attendees who are invited based on the topics being discussed. Recently, the group was joined by a new provider, Community Substance Abuse Centers (CSAC), which is opening a new OTP just inside the New Hampshire border that will serve clients from Maine and New Hampshire. The goals of this workgroup are to share information, build knowledge, enhance their awareness of issues, and set common goals. Review of the minutes of the past year indicates that the Opioid Treatment Workgroup has regularly shared information about developments in each individual program, as well as about issues of general interest, including buprenorphine, adolescent waivers, MaineCare transportation, Hepatitis C testing, take-home dosing and dry dosing, exception requests, and a public relations campaign. This forum provides a means for OTPs to collaboratively build a stronger opioid treatment system for Maine. Since three of the four Maine OTPs are managed by for-profit corporations, the OTPs are not active participants in the Maine Association of Substance Abuse Treatment Providers, which is an organization of the not-for-profit providers. This Opioid Treatment Workgroup provides an alternative for the OTPs to meet with colleagues.

Fatal Opiate Overdose Prevention Advisory Group - City of Portland

The Fatal Opiate Overdose Prevention Advisory Group, a task force spearheaded by the City of Portland Health and Human Services Department, has been meeting since October 2002 and has released a Comprehensive Opiate Overdose Death Prevention Strategy: A Public Health Response (October 2002). This group focuses specifically on public health strategies for the greater Portland area to address fatal drug overdoses. The group defines two goals:

- To build community capacity to address the public health issue of fatal drug overdoses
- To reduce the incidence of fatal drug overdoses

The group has secured grant funding to support the hiring of a half-time staff person to lead the implementation of the group's strategy. The Fatal Opiate Overdose Prevention Advisory Group is taking a multi-faceted approach designed to:

- Improve knowledge by improving the Fatal Opiate Overdose Prevention Advisory Group's capacity to access and compile data to define the issues and evaluate the success of the initiatives, providing public education and advocacy, and developing a media campaign.
- Reduce risk of overdose by making it safer to call 911, making Naloxone available to first responders, and investigating Naloxone prescription and distribution to users and their families.

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- Increase outreach by working with harm reduction groups and other programs to engage and educate active opiate users in overdose prevention, recognition, and response.

The Fatal Opiate Overdose Prevention Advisory Group established a set of task-oriented workgroups that have engaged representatives from a number of other related agencies to help the Advisory Group improve their knowledge, develop good working relationships, and plan and implement specific strategies.

F. SUMMARY

In the past year, OSA has taken the lead and mobilized a wide-range of partners in addressing drug-related deaths. OSA appears to have been effective in managing the crisis, developing partnerships, facilitating productive workgroups, problem-solving to improve patient care, and keeping public safety as paramount. The experience has put everyone on a steep learning curve about opioid addiction and treatment, but the work has established partnerships and an infrastructure that can continue to work on issues.

Review of the minutes of the Opioid Treatment Work Group and the Portland Fatal Opiate Overdose Prevention Group from the past year indicates that attendees included representatives of the following:

- BDS Licensing
- Cumberland County Medical Examiner
- Cumberland County Sheriff
- Cumberland County Jail
- Cumberland County District Attorney
- Greater Portland Area Police Departments
- Harm Reduction Alliance
- Intravenous Drug User Peer Advisory Group
- Maine DEA
- Maine State Police
- Maine Medical Center Emergency Room
- Maine Association of Substance Abuse Providers
- Mercy Hospital
- Office of Substance Abuse
- Office of Attorney General
- Opioid Treatment Providers
- Pharmacy Board
- Portland and State Public Health
- Substance Abuse Treatment Services Providers
- State Emergency Medical Services

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- United States Attorney

The number and diversity of entities represented on this list illustrates the extent to which OSA has succeeded in engaging numerous public and private sectors in addressing the issues of opioid treatment in Maine.

IV. Key Findings

In reviewing the numerous activities and initiatives undertaken in the past year to help Maine move forward in developing a stronger opioid treatment system, a number of key findings were identified.

A. CHANGING ROLE OF THE STATE METHADONE AUTHORITY

The function of the SMA has remained relatively constant over the past several decades. For many SMAs, that function is a small component of their role at their State agencies. The new CSAT regulations (42 CFR part 8) were released in May 2001 regarding OTPs. CSAT and SMAs are working together on defining and clarifying the role of the SMA under the new CSAT approach to opioid treatment regulation. It was clear to CSAT and SMAs that this relationship was needed to provide the best oversight of care to this patient population.

As the overall approach to opioid treatment regulation moves to an emphasis on an accreditation-based approach with more flexibility, States are finding that they have to redefine the role of SMA to meet the needs of the treatment system for opioid dependent patients. Specifically, the role of SMA is changing from oversight of methadone, to oversight of the care of patients that receive medication-assisted treatment. The SMA role formerly was primarily regulatory, looking at regulation and safety of methadone in the community itself. Today, many SMAs have approached this function with a TA approach, working collaboratively with providers to increase access and quality care to people with this dependency, and placing a focus on opioid services verses medication-specific regulations. The scope of oversight may include the full continuum of services as opiate dependent patients move to different levels of care within the substance abuse treatment system.

Maine is redefining its SMA to work within the new regulatory approach and to meet the specific needs of the State. Because of the intense attention given to OTPs in the past year, the SMA in Maine has necessarily been attentive to specific regulatory responsibilities typically assigned to SMA—especially responding to requests for exceptions. As OSA refines its approach to opioid treatment, the role of the SMA will continue to evolve to provide the support needed.

B. OPIOID TREATMENT PROVIDER COMMUNITY

The Maine opioid treatment system is very young. The current providers in Maine brought experience from other sites across the country but are staffed primarily with individuals who have limited experience with opioid treatment. The treatment of Maine residents may have been a new challenge to the OTPs as they treat patients new to opioid treatment and also relatively new to their addiction. Maine is faced with the challenge of lacking depth of experience and absence of models to guide the development of new programs. Regular meetings of the OTPs have been effective in forming a sense of a statewide opioid treatment system. Even though the for-profit programs are competitors on one level,

the regular meetings have engendered a spirit of collaboration and mutual assistance that is extremely valuable. These meetings give the SMA a natural forum to introduce new ideas and also to hear emerging concerns from the field.

C. CAPACITY MANAGEMENT—CERTIFICATION OF NEED

Maine currently has four established OTPs, three of which are managed by for-profit organizations. Three of the OTP programs were established in the past five years. OSA staff report there have been several calls from out-of-State agencies to BDS inquiring about the requirements to establish an OTP program in Maine. The Technical Review team was not able to determine the requirements for a certificate of need (CON) process for establishing an OTP. It appears that no formal process was used for determining the need for the current OTPs. Therefore, with inquiries by other potential OTP providers, a reported wait list of clients for the current programs, and an identified need for a program in several areas of the State, it may be in OSA's best interest to help ensure that decisions about establishing future programs are made based on areas of need.

Typically, a CON process to establish new OTPs should:

- Ensure that the need for services is clearly demonstrated.
- Ensure that newly approved programs would not compete for clients with existing programs.
- Provide an opportunity for public input, input by affected individuals, and accountability through review processes, preapproval hearings, and printed notification.
- Ensure cross-agency integration. A tiered system of OTP approval is important to understanding how these facilities are regulated by State government agencies.

The criteria to determine need may include:

- Estimated number of persons with addiction problems, particularly opiate addiction problems
- Reports of opiate-related deaths
- Arrests for sale and illegal possession of opioids in the area
- Number of persons with opiate-related issues served by existing programs
- Travel hardships for clients traveling over 50–100 miles round trip for services

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- Number of persons on the waiting lists of existing programs who are in need of opiate-related treatment services
 - Utilizing nationally recognized formulas for estimating need

Data to assist in establishing need may be forthcoming from CESN. This ongoing source of data on drug abuse trends could prove to be valuable to OSA not only as a tool for establishing OTPs, but in managing the overall substance abuse treatment system.

D. WAIT LIST MANAGEMENT

OSA's patient data system for 2002 indicates that 14.4 percent of patients entering treatment had a primary diagnosis of opiate abuse/dependency, and 5 percent of all patients entering treatment were entered into an OTP. It is not clear what type of treatment the remaining patients are receiving for their opioid addiction, or what the characteristics of those patient are. The OSA patient database could cross reference client zip code and primary drug of abuse to help estimate unmet need. OSA may need to gather additional data through a needs assessment specific to opioids but inclusive of all alcohol and drugs.

Interviewees provided conflicting reports as to whether OTP providers have stopped adding clients to their waiting list because the list is so long or whether there is a waiting list at all. This question will be addressed in Phase II of this State-Requested Technical Review of OTPs. Even within BDS, conflicting reports on waiting lists exist. The varying perceptions by interviewees of the waiting list issue underscores a need to (1) provide accurate information on waiting lists for OTP programs and (2) analyze the potential clients on the waiting list to track trends and identify current or emerging populations of clients who may, or may not, need to move to priority status, even if only for a prescribed/defined period of time.

OSA has several options to systematically monitor the waiting lists. Provider contracts require all providers to report on their waiting lists by the 15th of each month for the previous month. Programs with multiple sites must report by site to OSA. OSA may want to begin examining the waiting lists at regular intervals to analyze the number and type of clients on the list. This process could help OSA assess the immediate capacity needs and track referrals to see how many opiate-using clients may enter other abstinence-based programs or hospitals or be eligible for buprenorphine treatment. OSA also may be able to track whether opiate overdose deaths were clients who were on a waiting list for OTP. Currently, providers report wait lists manually; however, OSA may want to consider instituting electronic wait list reporting and management for OTPs and/or all contracted treatment programs. An electronic system could track priority populations, length of time on waiting list, and current program capacity.

E. PROGRAM MONITORING

All four OTPs have received national accreditation and two-year licenses from BDS. However, while these accomplishments indicate that the programs have met the specified standards, OSA is continuing to provide ongoing monitoring to ensure that the programs operate consistently at the standards that have been set and provide high quality services.

OSA utilizes a number of monitoring opportunities to assess quality. Monitoring is performed primarily by the Treatment Unit of OSA which consists of three staff. Oversight of OTPs is a small part of the Treatment Unit's responsibilities since the unit oversees approximately 98 substance abuse treatment programs. The Treatment Unit manager is also the designated SMA. One staff member assists with State exemptions for methadone and another assists with clinical TA. Monitoring activities include routine, for cause, and as-needed licensure visits, investigative visits, and follow-up visits to monitor progress with any corrective action plans. There are occasions when the SMA accompanies the licensure staff on some of these visits. In addition, the SMA and other OSA staff have conducted their own site visits and produced reports documenting the results of the site visit. For example, in May 2002, when the news media began reporting on apparent drug overdose deaths, OSA constituted a team of OSA and licensing staff to do a site review of the two Portland OTPs primarily to examine dosing and take-home practices and diversion control practices.

OSA convenes a monthly Agency Monitoring Meeting to review contracting issues, identify underperforming programs that may require focused attention, and discuss any licensure issues and concerns. Other OSA staff receive and review the Agency Monitoring List and the Effectiveness Indicator Report (performance indicator reports). The results of this information are available for review and discussion to the participants in the monthly Agency Monitoring Meeting.

One area that could add to OSA's capabilities to assess quality is the information and expertise available from the Pharmacy Board. The Pharmacy Board conducts routine and investigative visits to the pharmacies at the OTPs to assess whether the control of storage and distribution of pharmaceutical drugs meets standards. Keeping informed of the status of the pharmacy operations at the OTPs (including pharmacy staffing and program compliance with the requirements for dispensing and accounting for the methadone), could be helpful to OSA in spotting trends, emerging issues, and potential problems before they escalate.

OTPs do not have contracts with OSA for SAPT Block Grant funds; however, OTPs do have contracts to provide Medicaid-funded services. The Medicaid contract language could be modified to incorporate quality improvement planning and measurement of patient outcomes, which could be helpful to OSA in improving service quality. This contract language could include number and frequency of

counseling sessions, quality of treatment plans, documentation requirements, and expected client outcomes.

F. OUTCOME MANAGEMENT

OSA-contracted providers have been contractually required to report on a series of performance criteria. The contracts list performance indicators and the minimal standards of expected performance. OSA staff reported that providers have been required to report on the performance criteria since 1992. OSA established a Performance Based Contracting Workgroup (PBCW) and one of the charges of this group was to identify performance indicators and standards of performance. The performance criteria listed in OSA contracts specifically cover all levels of care except methadone maintenance. OSA assigned the non-intensive outpatient criteria to OTPs, but these criteria are somewhat inappropriate for OTPs. However, OSA staff report that the PBCW will reconvene to develop performance criteria for OTPs. This presents an opportunity for OSA to identify critical performance indicators that would assist in assessing the quality of care provided by OTPs. Some possible indicators could be toxicology screens and retention in treatment.

OSA does not have a formalized protocol connecting funding to performance. In addition, OSA's contract standards, processes, and procedures have not been formalized in a manual. As OSA begins to document contract standards, policies, and procedures, OSA may want to consider what consequences are reasonable and enforceable for underperforming programs. Even though OSA contributes the full share of the Medicaid "seed" (State General Funds) and methadone maintenance programs receive as much as 65 percent of all of their funding on a fee-for-service basis from Medicaid, OSA is not currently involved in Medicaid reimbursement mechanisms. OSA may want to consider collaborating with the State Medicaid agency to determine what measures may be instituted to assist OSA in enforcing fiscal consequences for underperforming.

G. OVERSIGHT OF METHADONE

Prescription Drug Monitoring

The prescription drug monitoring program bill passed in May 2003 provides for an electronic information system that monitors prescribing patterns of Schedule II, III, and IV controlled substances. The electronic information system program will have the capability of identifying clients receiving prescription opiates or methadone from several different physicians and help identify physician prescribing abuses. OSA is the lead agency for the program. OSA estimates it will take one year to get the program operational and an additional year before the program supplies sufficient data to be useful. OSA may want to consider working closely with the Pharmacy Board staff during the development and implementation phase to help ensure that issues relevant to OSA's needs will be addressed by the program.

Office-Based Opiate Treatment

An issue that may require the attention of OSA is the potential development of office-based opiate treatment (OBOT). The Drug Addiction Treatment Act of 2000 (DATA 2000) allows qualified physicians to treat opioid addiction with Schedule II, III, and IV controlled substances, or combinations of such controlled substances that have received FDA approval for this indication. DATA 2000 allows qualified physicians to dispense and prescribe these medications in an office-based setting, so that opioid addiction therapy can be provided in the mainstream of medical practice. DATA 2000 also requires special DEA registration for physicians, as well as limits on the number of patients individual physicians are allowed to treat (30). OSA staff reported that 12 physicians in Maine have been certified to provide OBOT; therefore, some OTP clients may opt in the future for OBOT. OSA will need to monitor the development of this emerging therapy.

H. LICENSING

The BDS licensing unit is currently in the midst of changing regulations and is attempting to combine mental health and substance abuse into one set of regulations. The current opioid treatment regulations addressed the minimum standards that existed in the FDA regulations. When 42 CFR part 8 regulations were adopted for use in May 2001, the State of Maine adopted the same regulations. The previous take-home regulations allowed for programs to be open six days a week. The providers in Maine followed this structure and all patients received a dose on Saturday to take at home on Sunday. In June 2002, as part of the State response to the overdose deaths, the SMA sent all programs a letter instructing that programs were to be open seven days-a-week and that all 14- and 30-day take home requests were to be by State approval through the State exemption form. SMA indicates that these restrictions are still in effect, and that the State is receiving many requests for take-home doses by exemption. However, the rule is in memo form only, and provider compliance may be an issue. As Maine finalizes its own regulations, OSA will need to determine clear take-home regulations that find a balance between current federal regulations (42 CFR part 8) and Maine's need to ensure patient access, as well as public safety.

Some other issues OSA may wish to consider as it completes revision of the regulations include the following:

- Bring the quality of substance abuse treatment regulations up to the level of mental health standards. For example, it appears that mental health has regulations that address patient rights and grievances that do not currently exist in substance abuse treatment regulations.
- Define SMA and licensing roles in the grievance process, and include written language that makes the process clear to the patient and the program.

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- Consider emergency amendment for OTP's to clarify take-home regulations and any other issues needing clarification at this time if promulgation of regulations is not imminent.
 - Consider regulations for substance abuse agencies regarding definitions and internal protocols for reporting critical incidents.

V. Conclusions

OSA, the city of Portland, and the State of Maine have experienced a flood of publicity in the past year precipitated by an increasing number of apparent drug overdose deaths. Maine appears to have been just ahead of the curve in experiencing this crisis, as other States have begun reporting similar phenomena. OSA's response was to assume leadership in addressing the crisis and to aggressively promote education about opioid addiction and treatment while simultaneously engaging partners from many sectors of the community to share ownership of the problem. The problem is being treated as a public health problem and responses are being developed accordingly. Workgroups and task forces are moving actively to accomplish specific interventions that will reduce the risk of harm to citizens. Research studies, evaluations, and data collection processes are being conducted to build a strong database of current information about the evolving nature of the problem and the effectiveness of the solutions that are being implemented. While regulation of controlled substances and legal action against those who are breaking the law continue, the Technical Review team also heard strong voices that are advocating for more and better opioid treatment.

Some of the key issues that will need further attention include the following:

- The existing OTPs are all licensed and have received national accreditation; however, all the programs will need ongoing monitoring for OSA to remain confident that quality care is being delivered utilizing best practices, and that the treatment practices are compatible with public safety concerns of the State's citizens.
- The substance abuse treatment community is just beginning to acknowledge the place that treatment that is not drug-free has in the substance abuse treatment continuum. OSA has made extensive efforts to inform and educate other substance abuse treatment providers about the place of opioid treatment in the continuum of care. Over time, if opioid treatment can be integrated into the substance abuse treatment continuum, clients will have better options for choosing which treatment modality is most appropriate for them. When opioid treatment operates "independently," the clients being served do not have access to the support of auxiliary services, including other substance abuse services and mental health services.
- The need continues for much more education and information. It will be important for citizens to understand that opioid addiction is a potentially fatal disease, and to be aware of the impact and effects of this addiction.
- The medical community will profit from additional education on treating addiction, including opiate addiction.

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- The opioid addiction scene is volatile and will continue to change. Based on information gathered by the Technical Review team, the indications are that opioid use will continue to rise in Maine. The treatment system will need to continue to evolve to meet the changing needs.

While some of the factors that contributed to overdose deaths have been addressed, knowledgeable treatment professionals indicate that all these efforts will not completely eliminate overdose situations. The success of the well-coordinated response made by the State of Maine to the crisis over the past year suggests that oversight and direction of opioid treatment will have a greater probability of success if opioid addiction continues to be addressed as a public health concern and opioid treatment is integrated into the substance abuse treatment system.

VI. Technical Assistance Recommendations

Table III-1 on page 29 was completed by the designated State official responsible for advising CSAT on the State agency's TA needs, following his or her review of Draft 1 of the Technical Review report. The purpose of including this form in the Draft 1 Technical Review report is to help expedite TA planning and delivery by giving CSAT staff an early alert on the State's needs. However, CSAT recognizes that TA priorities can change over time. Consequently, the State may reorder its priorities or change the scope of its TA requests during the TA planning and implementation process. This final version of the Technical Review report includes updated information on the State's TA priorities and delivery time frame preferences.

The following are more detailed descriptions of the TA recommendations for the State of Maine:

Education on Opiate Addiction and Treatment—The State of Maine could benefit from TA for the design and delivery of education on opioid addiction and treatment, particularly for the substance abuse treatment providers, the mental health treatment providers, the medical community, and judges.

Licensing Regulations—The State of Maine could benefit from TA on developing new licensing regulations for opioid treatment programs that conform to the new CSAT guidelines and meet the needs of the Maine community.

Defining SMA Role and Responsibilities—The State of Maine could benefit from TA on redefining the role and responsibilities of SMA.

Certificate of Need Process for New Opioid Treatment Programs—The State of Maine could benefit from TA on developing a certificate of need process for guiding the development of new opioid treatment programs.

Performance and Treatment Outcome Measures for OTPs—The State of Maine could benefit from TA on defining performance indicators and treatment outcomes appropriate for OTPs.

Prescription Drug Monitoring—The State of Maine could benefit from TA on designing and buying/building a prescription drug monitoring system to learn what other States have done and to determine what systems are available commercially that would meet Maine's needs.

Table III-1. Maine TA Recommendations Summary

State's TA Priority Number	Technical Review Team's TA Recommendations	Report Section and Page	State's Preference for TA Delivery (Month/Year)
1	Education on Opiate Addiction and Treatment	III. p. 10	November 2003
5	Licensing Regulations	III. p. 14	September 2004
3	Defining SMA Role and Responsibilities	IV. p. 19	February 2004
6	Certificate of Need Process for New Opioid Treatment Programs	IV. p. 21	September 2004
4	Performance and Treatment Outcome Measures for OTPs	IV. p. 23	March 2004
2	Prescription Drug Monitoring	IV. p. 23	October 2003

Appendix A. Maine Interviewee List

Representative	Organization
Ann Levesque, Licensor	Department of Behavioral and Developmental Services
Greg Cameron	Board of Pharmacy
Jamie Clough, Data and Research Team Manager	Office of Substance Abuse
Jeffrey Toothaker, Fiscal Team Manager	Office of Substance Abuse
Jim Cameron, Assistant Attorney General	Attorney General's Office
Joanne Ogden, Treatment Team Manager	Office of Substance Abuse State Methadone Authority
John Burton, MD, Director	State Emergency Medical Services and Maine Medical Center Emergency Room
Kimberly Johnson, Director	Office of Substance Abuse
Liz Harper, Director of Licensing	Department of Behavioral and Developmental Services
Paul MacFarland, Substance Abuse Treatment Specialist	Office of Substance Abuse
Roy McKinney, Director	Maine Drug Enforcement Agency
Scott Pelletier	Maine Drug Enforcement Agency and Portland Police Department

Appendix B. Acronyms Relevant to the Maine Technical Review

BDS	Department of Behavioral and Developmental Services
CAP	Center for Addictive Problems
CARF	CARF...The Rehabilitation Accreditation Organization
CESN	Community Epidemiology Surveillance Network
COA	Council on Accreditation for Child and Family Services
CON	certificate of need
CSAC	Community Substance Abuse Centers
CSAT	Center for Substance Abuse Treatment
DATA 2000	Drug Addiction Treatment Act of 2000
FDA	Food and Drug Administration
JCAHO	Joint Commission for the Accreditation of Healthcare Organizations
OBOT	office-based opiate treatment
OSA	Office of Substance Abuse
OTPs	opioid treatment programs
SAPT	Substance Abuse Prevention and Treatment
SMA	State Methadone Authority
SPO	State Project Officer
SSA	Single State Authority
SSDP	State Systems Development Program
TA	technical assistance